House Health Subcommittee Am. #1

Amendment No._____

FILED
Date _____
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Comm. Amdt. _____

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Signature of Sponsor

AMEND Senate Bill No. 2359* **House Bill No. 2675**

by deleting the language "county or district health department" and substituting the language "a county or district health department" in Section 1.

AND FURTHER AMEND by adding the following section and redesignating the effective date section:

SECTION 6. Tennessee Code Annotated, Section 68-1-136, is amended by adding the following as a new subsection (j):

Needle and hypodermic syringe exchange programs established under subsection (i) shall be funded entirely by the county legislative body making petition to the county or district health department.

House Health Subcommittee Am. #1

Amendment No._____

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Signature of Sponsor

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AMEND Senate Bill No. 1873 **House Bill No. 1758***

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 68-140-304, is amended by adding the following as a new subdivision:

(13) Certify emergency medical technician (EMT) and advanced emergency medical technician (AEMT) training centers operated by ambulance services to provide training for career EMTs and AEMTs.

SECTION 2. Tennessee Code Annotated, Title 68, Chapter 140, Part 3, is amended by adding the following as a new section:

In order to be certified by the board pursuant to § 68-140-304(13), a training program offered by an EMT/AEMT training center must follow the National EMS Scope of Practice Model for Emergency Medical Service Personnel as promulgated by the U.S. department of transportation, national highway traffic safety administration. Ambulance services licensed in this state may establish an EMT/AEMT training program. Additionally, the ambulance service must have an instructor coordinator approved by the division of emergency medical services who serves as the training coordinator or lead instructor for the ambulance service.

SECTION 3. This act shall take effect upon becoming a law, the public welfare requiring it.

House Health Subcommittee Am. #2

Amendment No._____

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Date _____
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Signature of Sponsor

AMEND Senate Bill No. 1873 **House Bill No. 1758***

by adding the following sentence at the end of the amendatory language of Section 2:

The ambulance service must charge a special enrollment fee of one hundred seventy-five dollars ($175) to each student to be paid directly to the division of emergency medical services to offset administrative costs.

House Health Subcommittee Am. #1

Amendment No._____

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Signature of Sponsor

AMEND Senate Bill No. 2095* House Bill No. 2510

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. The commissioner of mental health and substance abuse services shall convene a working group to examine the potential impact of authorizing advance practice nurses and physician assistants in this state to prescribe buprenorphine containing products for the treatment of opioid use disorder and any potentially appropriate clinical settings for any such prescribing authority. The working group shall include at least one (1) representative from the Tennessee department of health, the Tennessee department of mental health and substance abuse services, the Tennessee bureau of investigation, the Tennessee Association of Chiefs of Police, the Tennessee Medical Association, the Tennessee Nurses Association, the Tennessee Academy of Physician Assistants, the Tennessee Society of Addiction Medicine, the Tennessee Recovery Coalition, the Tennessee Association of Alcohol, Drug, and Other Addiction Services, the Tennessee Association of Mental Health Organizations, Neighborhood Health, and a facility licensed as a nonresidential office-based treatment facility by the department of mental health and substance abuse services.

SECTION 2. Any costs associated with participation in the working group shall be borne by the individual participants or their respective associations or organizations and not by the state of Tennessee, except for those who are employed by this state. In no event shall this working group require the hiring of additional staff by this state.

SECTION 3. No later than February 1, 2019, the working group shall submit a report regarding its findings and recommendations to the commissioner of mental health and substance abuse services, the commissioner of health, the health committee of the house of

representatives, and the health and welfare committee of the senate, at which time the working group shall cease to exist.

SECTION 4. This act shall take effect upon becoming a law, the public welfare requiring it.

House Health Subcommittee Am. #1

Amendment No._____

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Signature of Sponsor

AMEND Senate Bill No. 2646 House Bill No. 2326*

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Title 4, Chapter 3, Part 7, is amended by adding the following as a new section:

(a) This section shall be known and may be cited as the "Tennessee Rural Hospital Transformation Act of 2018."

(b) As used in this section:

(1) "Advisory committee" means a committee convened as often as necessary by the department that is composed of one or more representatives from each of the following: department of health, department of labor and workforce development, bureau of TennCare, board of regents, and other public and private stakeholders as deemed appropriate by the department;

(2) "Contractor" means individual consultants or professional firms, preferably with rural healthcare experience and expertise;

(3) "Department" means the department of economic and community development;

(4) "Rural hospital" means a hospital located outside of a major urban or suburban area; provided, that the hospital may be located within a metropolitan statistical area;

(5) "Rural hospital transformation program" refers to a program administered by the department to support rural hospitals in assessing viability and identifying new delivery models, strategic partnerships, and operational

changes that enable the continuation of needed healthcare services in rural communities;

(6) "Target hospital" means a rural hospital determined to be eligible by the state for the rural hospital transformation program; and

(7) "Transformation plan" means a strategic plan developed by one or more contractors in close collaboration with target hospitals and community stakeholders to provide recommendations and actionable steps for preserving healthcare services in the target hospital community.

(c)

(1) The department, in consultation with the advisory committee, shall establish and manage the rural hospital transformation program.

(2) The department, in consultation with the advisory committee, shall identify one or more contractors to provide consultations to target hospitals for the creation of transformation plans, which shall include:

(A) Focused strategies for transitioning the hospital into a sustainable business model in order to avoid or prevent closure;

(B) Recommendations for utilizing transformation funding to offset transition costs;

(C) Recommendations for funding remaining transitions costs with hospital or community resources;

(D) Recommendations for ensuring that appropriate and viable services are provided in the target hospital community, serving the best interests of the patients and caregivers;

(E) Recommendations for strategic partnerships and alliances where practical; and

(F) Where partnerships are not practical, recommendations for coordination with the surrounding healthcare community including safety-net providers and tertiary hospitals.

(3) Target hospitals may submit applications to the department for review and approval to receive consultation from identified contractors for the development of a transition plan. The content of applications shall be directed by the department in consultation with the advisory committee.

(d) Transformation plans shall be developed through collaboration between the contractor, target hospital, target hospital community stakeholders, and other appropriate stakeholders.

(e) Finalized transformation plans shall include a timeline for implementation and must be submitted to the department.

(f) The department shall receive periodic updates on the implementation of the transformation plans and monitor the progress of target hospitals.

SECTION 2. This act shall take effect on July 1, 2018, the public welfare requiring it.

House Health Subcommittee Am. #1

Amendment No._____

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Signature of Sponsor

AMEND Senate Bill No. 2257 **House Bill No. 1831***

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 53-10-303(f), is amended by deleting the subsection in its entirety and substituting the following:

(f) Pursuant to § 53-10-311 and the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, the commissioner shall have the authority to promulgate rules as necessary for implementation of this part regarding:

(1) Establishing, maintaining, and operating the database;

(2) Access to the database and how access is obtained;

(3) Control and dissemination of data and information in the database;

(4) The control, sharing, and dissemination of data and information in the database with other states or other entities acting on behalf of a state; and

(5) Establishing the morphine milligram equivalent calculation for an opioid drug contained in Schedules II-V for purposes of SECTION 6 of this act; provided, that if no such rule is promulgated for an opioid drug, the morphine milligram equivalent calculation established by the federal centers for disease control and prevention for that drug shall be used.

SECTION 2. Tennessee Code Annotated, Section 53-10-305(b)(1), is amended by redesignating the existing subdivision (b)(1)(L) as (b)(1)(N) and adding the following language as new subdivisions (b)(1)(L) and (M):

(L) The ICD-10 code for any prescription that contains an ICD-10 code; provided, that this shall not be mandatory prior to January 1, 2019, for a dispenser who has not updated the dispenser's software system to enable submission of ICD-10 codes;

(M) A value signifying opioid treatment is occurring pursuant to a medical necessity under SECTION 6 for any prescription containing the words "medical necessity." The value will be determined by the committee and published through the committee's website;

SECTION 3. Tennessee Code Annotated, Section 53-10-310, is amended by deleting subdivisions (e)(1) and (e)(2) in their entireties and substituting the following:

(e)

(1) When prescribing a controlled substance, all healthcare practitioners, unless otherwise exempted under this part, shall check the controlled substance database prior to prescribing one (1) of the controlled substances identified in subdivision (e)(4) to a human patient at the beginning of a new episode of treatment, prior to the issuance of each new prescription for the controlled substance for the first ninety (90) days of a new episode of treatment, and shall check the controlled substance database for that human patient at least every six (6) months when that prescribed controlled substance remains part of the treatment. An authorized healthcare practitioner's delegate may check the controlled substance database on behalf of the healthcare practitioner. A "new episode of treatment" means a prescription for a controlled substance that has not been prescribed by that healthcare practitioner within the previous six (6) months.

(2) When dispensing a controlled substance, all healthcare practitioners, unless otherwise exempted under this part, shall check the controlled substance database prior to dispensing one (1) of the controlled substances identified in subdivision (e)(4) to a human patient the first time that patient is dispensed a controlled substance at that practice site. The dispenser shall check the controlled substance database again at least once every six (6) months for that human patient after the initial dispensing for the duration of time the controlled substance is dispensed to that patient. The initial dispensing check fulfills the

check requirement for the first six-month period. An authorized healthcare practitioner's delegate may check the controlled substance database on behalf of the healthcare practitioner.

SECTION 4. Tennessee Code Annotated, Section 53-10-310, is amended by deleting subdivision (e)(6)(B) in its entirety.

SECTION 5. Tennessee Code Annotated, Section 53-10-310(e)(6)(C), is amended by deleting the language "seven-day treatment period" and substituting instead "three-day treatment period".

SECTION 6. Tennessee Code Annotated, Title 63, Chapter 1, Part 1, is amended by adding the following language as a new, appropriately designated section:

(a) As used in this section:

(1) "Encounter" means a single visit where an opioid is administered or an opioid prescription is issued or dispensed;

(2) "Healthcare practitioner" means a person licensed under this title who has the authority to prescribe or dispense controlled substances in the course of professional practice;

(3) "ICD-10 code" means the code established in the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) adopted by the federal centers for medicare and medicaid services, or the code used in any successor classification system adopted by the federal centers for medicare and medicaid services, that corresponds to the diagnosis of the condition being treated;

(4)

(A) "Informed consent" means consent voluntarily given in writing by the patient or the patient's legal representative after sufficient explanation and disclosure by the healthcare practitioner of the subject matter involved to enable the person whose consent is sought to make a knowing and willful decision. This explanation and disclosure by the

healthcare practitioner to the patient or the patient's legal representative before consent may be obtained must include, at a minimum:

(i) Adequate information to allow the patient or the patient's legal representative to understand:

(*a*) The risks, effects, and characteristics of opioids, including the risks of physical dependency and addiction, misuse, and diversion;

(*b*) What to expect when taking an opioid and how opioids should be used; and

(*c*) Reasonable alternatives to opioids for treating or managing the patient's condition or symptoms and the benefits and risks of the alternative treatments;

(ii) A reasonable opportunity for questions by the patient or patient's legal representative;

(iii) Discussion and consideration by the patient or the patient's legal representative and the healthcare practitioner of whether the patient should take an opioid medication; and

(iv) If the patient is a woman of childbearing age and ability, information regarding neonatal abstinence syndrome and specific information regarding how to access contraceptive services in the community. For purposes of this section, childbearing age is between the ages of fifteen (15) and forty-four (44);

(B) Nothing in subdivision (a)(4)(A) limits other requirements imposed on healthcare practitioners by law or applicable licensing authority;

(5) "Morphine milligram equivalent dose" means the morphine milligram equivalent calculation for the amount of a prescribed opioid, multiplied by the days of treatment; and

(6) "Treat" means prescribe, dispense, or administer.

(b) Except as provided in this section, a healthcare practitioner shall not treat a patient with more than a three-day supply of an opioid and shall not treat a patient with an opioid dosage that exceeds a total of a one hundred eighty (180) morphine milligram equivalent dose.

(c)

(1) A patient shall not be treated with an opioid more frequently than every ten (10) days; provided, however, that if the patient has an adverse reaction to an opioid, a healthcare practitioner may treat a patient with a different opioid within a ten-day period under the following circumstances:

(A) The healthcare practitioner is employed by the same practice that initially treated the patient with the opioid that caused the adverse reaction;

(B) The healthcare practitioner personally evaluates the patient, assesses the patient's adverse reaction, and determines a different course of treatment is more medically appropriate;

(C) The healthcare practitioner confirms with the dispenser that the remainder of the initial prescription has been cancelled by the dispenser;

(D) The healthcare practitioner counsels the patient to appropriately destroy any remaining opioids that were previously dispensed to the patient; and

(E) The healthcare practitioner's treatment of the patient conforms to the requirements of this section.

(2)

(A) Notwithstanding subdivision (c)(1), where the treatment provided by a healthcare practitioner is dispensing an opioid, the healthcare practitioner may treat a patient more than once within ten (10) days; provided, that the healthcare practitioner shall not dispense an opioid in an amount that exceeds the greater of:

(i) A five-day supply per encounter; or

(ii) Half of the total prescribed amount.

(B) The healthcare practitioner may dispense the remainder in a subsequent encounter.

(C) The partial fill requirements of this subdivision (c)(2) shall not be mandatory prior to January 1, 2019, for a dispenser who has not updated the dispenser's software system.

(d)

(1)

(A) A healthcare practitioner may treat a patient with more than a three-day supply of an opioid if the healthcare practitioner treats the patient with no more than one (1) prescription for an opioid per encounter and:

(i) Personally conducts a thorough evaluation of the patient;

(ii) Documents consideration of non-opioid and non-pharmacologic pain management strategies and why the strategies failed or were not attempted;

(iii) Includes the ICD-10 code for the primary disease in the patient's chart, and on the prescription when a prescription is issued; and

(iv) Obtains informed consent and documents the reason for treating with an opioid in the chart.

(B) A healthcare practitioner who is dispensing pursuant to a prescription written by another healthcare practitioner for more than a three-day supply of an opioid is not required to satisfy subdivisions (d)(1)(A)(i)-(iv) when filling a prescription that contains an ICD-10 code; provided, that the healthcare practitioner shall not dispense more than one (1) prescription for an opioid to a patient per encounter.

(2) If a healthcare practitioner treats a patient with more than a three-day supply of an opioid, the healthcare practitioner may treat the patient with no more than a ten-day supply and with a dosage that does not exceed a total of a five hundred (500) morphine milligram equivalent dose.

(3) Notwithstanding subdivision (d)(2), in rare cases where the patient has a condition that will be treated by a procedure that is more than minimally invasive and sound medical judgment would determine the risk of adverse effects from the pain exceeds the risk of the development of a substance use disorder or overdose event, a healthcare practitioner may treat a patient with up to a twenty-day supply of an opioid and with a dosage that does not exceed a total of an eight hundred fifty (850) morphine milligram equivalent dose.

(4) Notwithstanding subdivision (d)(2), in rare cases after trial and failure of reasonable, appropriate, and available non-opioid treatments for the pain condition or documenting the contraindication, inefficacy, or intolerance of non-opioid treatments, where medical necessity and sound medical judgment would determine the risk of adverse effects from the pain exceeds the risk of the development of a substance use disorder or overdose event, a healthcare practitioner may treat a patient with up to a thirty-day supply of an opioid and with a dosage that does not exceed a total of a one thousand two hundred (1,200) morphine milligram equivalent dose. The healthcare practitioner must include the phrase "medical necessity" on the prescription for any prescription issued pursuant to this subdivision (d)(4).

(e) The restrictions of this section do not apply to the following; provided, that where a prescription is issued pursuant to this subsection (e), the prescription contains the ICD-10 code for the primary disease documented in the patient's chart and the word "exempt":

(1) The treatment of patients who are undergoing active or palliative cancer treatment or who are receiving hospice care;

(2) The treatment of patients with a diagnosis of sickle cell disease;

(3) The administration of opioids directly to a patient during the patient's treatment at any facility licensed under title 68, chapter 11, or any hospital licensed under title 33, chapter 2, part 4;

(4) Prescriptions issued by healthcare practitioners who are:

(A) Pain management specialists, as that term is defined in § 63-1-301, or who are collaborating with a pain management specialist in accordance with § 63-1-306(a)(3); provided, that the patient receiving the prescription is personally assessed by the pain management specialist, or by the advanced practice registered nurse or physician assistant collaborating with the pain management specialist; or

(B) Treating patients in an outpatient setting of a hospital exempt under § 63-1-302(2) that holds itself out to the public as a pain management clinic.

(5) The treatment of patients who have been treated with an opioid daily for ninety (90) days or more during the three hundred sixty-five (365) days prior to April 15, 2018, or those who are subsequently treated for ninety (90) days or more under one (1) of the exceptions listed in subdivision (d)(4) or this subsection (e);

(6) The direct administration of, or dispensing of, methadone for the treatment of an opioid use disorder to a patient who is receiving treatment from a healthcare practitioner practicing under 21 U.S.C. § 823(g)(1);

(7) The treatment of a patient for opioid use disorder with products that are approved by the U.S. food and drug administration for opioid use disorder by a healthcare practitioner under 21 U.S.C. § 823(g)(2);

(8) The treatment of a patient with a product that is an opioid antagonist and does not contain an opioid agonist; or

(9) The treatment of a patient who has suffered a severe burn or major physical trauma, as those terms are defined by the controlled substance database committee by rule and adopted by the licensing boards created pursuant to title 63, and sound medical judgment would determine the risk of adverse effects from the pain exceeds the risk of the development of a substance use disorder or overdose event.

(f) The commissioner of health, in consultation with the regulatory boards created pursuant to this title that license healthcare practitioners, shall study and analyze the impact and effects of the restrictions and limitations set forth in this section. No later than November 1, 2021, the commissioner shall issue a report relative to the impact and effects of the restrictions and limitations to the governor, the health and welfare committee of the senate, and the health committee of the house of representatives. The report may include recommendations for revisions to the restrictions on the prescription of opioids.

(g) This section applies only to the treatment of human patients.

SECTION 7. Tennessee Code Annotated, Title 63, Chapter 10, Part 2, is amended by adding the following as a new section:

(a) The general assembly finds that patient access to information about controlled substances is crucial to combating the deadly opioid epidemic in this state and that any obstacle to patients' receiving information about controlled substances is a serious threat to public health.

(b) Any agreement purporting to limit the ability of a pharmacist to discuss any issue related to the dispensing of a controlled substance with a patient is contrary to the

public policy of this state and is void and unenforceable. This includes, but is not limited to, information about the risks, effects, and characteristics of the controlled substance; what to expect when taking the controlled substance and how the controlled substance should be used; reasonable alternatives to the prescribed controlled substance; and any applicable cost sharing for a controlled substance or any amount an individual would pay for a controlled substance if that individual were paying cash.

SECTION 8. If any provision of this act or the application of any provision of this act to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act that can be given effect without the invalid provision or application, and to that end, the provisions of this act are declared to be severable.

SECTION 9. Sections 1 and 6 of this act shall terminate on July 1, 2023, and the law in effect prior to this act's effective date shall be restored.

SECTION 10. For rulemaking purposes, this act shall take effect immediately, the public welfare requiring it. For all other purposes, this act shall take effect July 1, 2018, the public welfare requiring it.

House Health Subcommittee Am. #1

Amendment No._____

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Signature of Sponsor

AMEND Senate Bill No. 2363 **House Bill No. 1728***

by adding the following language at the end of the amendatory language of Section 1:

This section shall not apply to any healthcare services provided at a pain management clinic as defined in § 63-1-301.

House Health Subcommittee Am. #1

Amendment No._____

Signature of Sponsor

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AMEND Senate Bill No. 2155 **House Bill No. 2001***

by deleting all the language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 71-5-151, is amended by designating the existing language as subsection (a) and adding the following as a new subsection (b):

(b)

(1) In developing or implementing any payment reform initiative involving the use of episodes of care with respect to medical assistance provided under this chapter by the bureau of TennCare, a healthcare provider shall not be required to pay the portion of the risk sharing payment that is attributable to the increased cost of pain relief services if the following conditions are met:

(A) The healthcare provider is required to make an episodes of care risk-sharing payment to a managed care organization;

(B) Some portion of the episode costs were due to pain relief services;

(C) The pain relief services provided to the patient were more expensive than an alternative pain relief service; and

(D) The provider can demonstrate that the pain relief services provided to the patient had the effect of reducing opioid use by the patient relative to an alternative pain relief service routinely used by other providers in the episode.

(2) The bureau of TennCare is authorized to promulgate rules, pursuant to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, as may be necessary to implement this section.

SECTION 2. This act shall take effect July 1, 2018, the public welfare requiring it.

House Health Subcommittee Am. #1

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Amendment No._____

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Signature of Sponsor

AMEND Senate Bill No. 2026 House Bill No. 2084*

by deleting all language following the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Title 71, Chapter 5, is amended by adding the following as a new part:

71-5-1701. This part shall be known and may be cited as the "Annual Coverage Assessment Act of 2018."

71-5-1702.

As used in this part, unless the context otherwise requires:

(1) "Annual coverage assessment" means the annual assessment imposed on covered hospitals as set forth in this part;

(2) "Annual coverage assessment base" means a covered hospital's net patient revenue as shown in its medicare cost report for its fiscal year that ended during calendar year 2008, on file with CMS as of September 30, 2009, subject to the following qualifications:

(A) If a covered hospital does not have a full twelve-month medicare cost report for 2008 on file with CMS but has a full twelve-month cost report for a subsequent year, the first full twelve-month medicare cost report for a year following 2008 on file with CMS shall be the annual coverage assessment base;

(B) If a covered hospital was first licensed in 2014 or later and did not replace an existing hospital, and if the hospital has a medicare cost report on file with CMS, the hospital's initial cost report on file with

CMS shall be the base for the hospital assessment. If the hospital does not have an initial cost report on file with CMS but does have a complete twelve-month joint annual report filed with the department of health, the net patient revenue from the twelve-month joint annual report shall be the annual coverage assessment base. If the hospital does not have a medicare cost report or a full twelve-month joint annual report filed with the department of health, the annual coverage assessment base is the covered hospital's projected net patient revenue for its first full year of operation as shown in its certificate of need application filed with the health services and development agency;

(C) If a covered hospital was first licensed in 2014 or later and replaced an existing hospital, the annual coverage assessment base shall be the replacement hospital's initial medicare cost report on file with CMS. If the hospital does not have a medicare cost report on file with CMS, such hospital's annual coverage assessment base shall be either the predecessor hospital's net patient revenue as shown in its medicare cost report for its fiscal year that ended during calendar year 2008, or, if the predecessor hospital does not have a 2008 medicare cost report, the cost report for the first fiscal year following 2008 on file with CMS;

(D) If a covered hospital is not required to file an annual medicare cost report with CMS, then the hospital's annual coverage assessment base shall be its net patient revenue for the fiscal year ending during calendar year 2008 or the first fiscal year that the hospital was in operation after 2008 as shown in the covered hospital's joint annual report filed with the department of health; and

(E) If a covered hospital's fiscal year 2008 medicare cost report

is not contained in any of the CMS healthcare cost report information system files and if the hospital does not meet any of the other qualifications listed in subdivisions (2)(A)-(D), then the hospital shall submit a copy of the hospital's 2008 medicare cost report to the bureau in order to allow for the determination of the hospital's net patient revenue for the state fiscal year 2018-2019 annual coverage assessment;

(3) "Bureau" means the bureau of TennCare;

(4) "CMS" means the federal centers for medicare and medicaid services;

(5) "Controlling person" means a person who, by ownership, contract, or otherwise, has the authority to control the business operations of a covered hospital. Indirect or direct ownership of ten percent (10%) or more of a covered hospital shall constitute control;

(6) "Covered hospital" means a hospital licensed under title 33 or title 68, as of July 1, 2018, except an excluded hospital;

(7) "Excluded hospital" means:

(A) A hospital that has been designated by CMS as a critical access hospital as of July 1, 2018;

(B) A mental health hospital owned by this state;

(C) A hospital providing primarily rehabilitative or long-term acute care services;

(D) A children's research hospital that does not charge patients for services beyond that reimbursed by third-party payers; and

(E) A hospital that is determined by the bureau as eligible to certify public expenditures for the purpose of securing federal medical assistance percentage payments;

(8) "Medicare cost report" means CMS-2552-96 or a subsequent form adopted by CMS for medicare cost reporting, the cost report for electronic filing of hospitals, for the period applicable as set forth in this section; and

(9) "Net patient revenue" means the amount calculated in accordance with generally accepted accounting principles for hospitals that is reported on Worksheet G-3, Column 1, Line 3, of the 2008 medicare cost report excluding long-term care inpatient ancillary revenues, or, in the case of a hospital that did not file a 2008 medicare cost report, comparable data from the first complete cost report filed after 2008 by such hospital.

71-5-1703.

(a) There is imposed on each covered hospital licensed as of July 1, 2018, an annual coverage assessment for fiscal year (FY) 2018-2019 as set forth in this part.

(b) The annual coverage assessment imposed by this part shall not be effective and validly imposed until the bureau has provided the Tennessee Hospital Association with written notice that includes:

(1) A determination from CMS that the annual coverage assessment is a permissible source of revenue that shall not adversely affect the amount of federal financial participation in the TennCare program;

(2) Either:

(A) Approval from CMS for the distribution of the full amount of directed payments to hospitals to offset unreimbursed TennCare costs as defined in § 71-5-1705(d)(2); provided, that no assessment installment shall be collected prior to the distribution of the installment of such directed payments;

(B) Approval from CMS for the distribution of the full amount of funds for uncompensated hospital costs set forth in the extension of the section 1115 demonstration project effective December 16, 2016;

provided, that the bureau shall prioritize the distribution of funds in the same manner as set forth in § 71-5-1704(i)(2)(A)(ii); or

(C) The rules proposed by the bureau pursuant to § 71-5-1704(i)(2); and

(3) Confirmation that all contracts between hospitals and managed care organizations comply with the hospital rate variation corridors set forth in § 71-5-161.

(c) The general assembly intends that the proceeds of the annual coverage assessment not be used as a justification to reduce or eliminate state funding to the TennCare program. The annual coverage assessment shall not be effective and validly imposed if the coverage or the amount of revenue available for expenditure by the TennCare program in FY 2018-2019 is less than:

(1) The governor's FY 2018-2019 recommended budget level; plus

(2) Additional appropriations made by the general assembly to the TennCare program for FY 2018-2019, except to the extent new federal funding is available to replace funds that are appropriated as described in subdivision (c)(1) and that are above the amount that the state receives from CMS under the regular federal matching assistance percentage.

(d)

(1)

(A) The general assembly intends that the proceeds of the annual coverage assessment not be used as justification for any TennCare managed care organization to implement across-the-board rate reductions to negotiated rates with covered or excluded hospitals or physicians in existence on July 1, 2018. For those rates in effect on July 1, 2018, the bureau shall include provisions in the managed care organizations' contractor risk agreements that prohibit the managed care

organizations from implementing across-the-board rate reductions to covered or excluded network hospitals or physicians either by category or by type of provider. The requirements of the preceding sentence shall also apply to services or settings of care that are ancillary to the primary license of a covered or excluded hospital or physician, but shall not apply to reductions in benefits or reimbursement for such ancillary services if the reductions:

(i) Are different from those items being funded in § 71-5-1705(d); and

(ii) Have been communicated in advance of implementation to the general assembly and the Tennessee Hospital Association.

(B)

(i) For purposes of this subsection (d), "services or settings of care that are ancillary to the primary license of a covered or excluded hospital or physician" includes all services where the physician or covered or excluded hospital, including a wholly owned subsidiary or controlled affiliate of a covered or excluded hospital or hospital system, holds more than a fifty percent (50%) controlling interest in such ancillary services or settings of care, but shall not include any other ancillary services or settings of care. For across-the-board rate reductions to ancillary services or settings of care, the bureau shall include appropriate requirements for notice to providers in the managed care organizations' contractor risk agreements.

(ii) For purposes of this subsection (d), "services or settings of care that are ancillary" means, but is not limited to,

ambulatory surgical facilities, free standing emergency departments, outpatient treatment clinics or imaging centers, dialysis centers, home health and related services, home infusion therapy services, outpatient rehabilitation, or skilled nursing services.

(iii) For purposes of this subsection (d), "physician" includes a physician licensed under title 63, chapter 6 or chapter 9, and a group practice of physicians that hold a contract with a managed care organization.

(2) This subsection (d) does not preclude good faith negotiations between managed care organizations and covered or excluded hospitals, hospital systems, and physicians on an individualized, case-by-case basis, nor is this subsection (d) intended by the general assembly to serve as justification for managed care organizations in this state, covered or excluded hospitals, hospital systems, or physicians to unreasonably deny any party the ability to enter into such individualized, case-by-case good faith negotiations. Such good faith negotiation necessarily implies mutual cooperation between the negotiating parties and may include, but is not limited to, the right to terminate contractual agreements, the ability to modify negotiated rates, pricing, or units of service, the ability to alter payment methodologies, and the ability to enforce existing managed care techniques or to implement new managed care techniques.

(3) This subsection (d) shall not preclude the full implementation of the requirements set forth in § 71-5-161.

(4) Notwithstanding this subsection (d), if CMS mandates a TennCare program change or a change is required by state or federal law that impacts rates, and that change is required to be implemented by the managed care organizations in accordance with their contracts, or if the annual coverage

assessment becomes invalid, then nothing in this part shall prohibit the managed care organizations from implementing any rate changes as may be mandated by the bureau or by state or federal law.

71-5-1704.

(a) The annual coverage assessment established for this part shall be four and fifty-two hundredths percent (4.52%) of a covered hospital's annual coverage assessment base.

(b) The annual coverage assessment shall be paid in installments pursuant to this subsection (b) if the requirements of § 71-5-1703(b) have been satisfied. The bureau shall establish a schedule of four (4) equal installment payments spread as evenly as possible throughout FY 2018-2019 with the first installment payment due either fifteen (15) days after the first FY 2018-2019 directed payments approved by CMS to offset unreimbursed TennCare costs have been made to hospitals, or if CMS does not approve directed payments to hospitals to offset unreimbursed TennCare costs, then fifteen (15) days after the first payment to hospitals under § 71-11-1705(d)(3).

(c) To facilitate collection of the annual coverage assessment, the bureau shall send each covered hospital, at least thirty (30) days in advance of each installment payment due date, a notice of payment along with a return form developed by the bureau. Failure of a covered hospital to receive a notice and return form, however, shall not relieve a covered hospital from the obligation of timely payment. The bureau shall also post the return form on its website.

(d) Failure of a covered hospital to pay an installment of the annual coverage assessment, when due, shall result in an imposition of a penalty of five hundred dollars ($500) per day until such installment is paid in full. The bureau at its discretion may waive the penalty in the event the hospital establishes that it mailed or electronically transferred payment to the state on or before the date the payment was due.

(e) If a covered hospital ceases to operate after July 1, 2018, and before July 1, 2019, the hospital's total annual coverage assessment shall be equal to its annual coverage assessment base multiplied by a fraction, the denominator of which is the number of calendar days from July 1, 2018, until July 1, 2019, and the numerator of which is the number of days from July 1, 2018, until the date the board for licensing healthcare facilities has recorded as the date that the hospital ceased operation.

(f) If a covered hospital ceases operation prior to payment of its full annual coverage assessment, then the person or persons controlling the hospital as of the date the hospital ceased operation shall be jointly and severally responsible for any remaining annual coverage assessment installments and unpaid penalties associated with previous late payments.

(g) If a covered hospital fails to pay an installment of the annual coverage assessment within thirty (30) days of its due date, the bureau shall suspend the payments to the hospital as required by § 71-5-1705(d)(2) or (3) until the installment is paid and report such failure to the department that licenses the covered hospital. Notwithstanding any other law, failure of a covered hospital to pay an installment of the annual coverage assessment or any refund required by this part shall be considered a license deficiency and grounds for disciplinary action as set forth in the statutes and rules under which the covered hospital is licensed.

(h) In addition to the action required by subsection (g), the bureau is authorized to file a civil action against a covered hospital and its controlling person or persons to collect delinquent annual coverage assessment installments, late penalties, and refund obligations established by this part. Exclusive jurisdiction and venue for a civil action authorized by this subsection (h) shall be in the chancery court for Davidson County.

(i)

(1) If any federal agency with jurisdiction over this annual coverage assessment determines that the annual coverage assessment is not a valid

source of revenue or if there is a reduction of the coverage and funding of the TennCare program contrary to § 71-5-1703(c), or if the requirements of §§ 71-5-161 and 71-5-1703(b) are not fully satisfied, or if one (1) or more managed care organizations impose rate reductions contrary to § 71-5-1703(d), then:

(A) No subsequent installments of the annual coverage assessment shall be due and payable; and

(B) No further payments shall be paid to hospitals pursuant to § 71-5-1705(d)(2) or (3) after the date of such event.

(2)

(A) Notwithstanding this part, if CMS discontinues approval of or otherwise fails to approve the full amount of directed payments or waiver supplemental hospital pool payments to hospitals to offset losses incurred from providing services to TennCare enrollees as authorized under § 71-5-1705(d), then the bureau shall suspend any payments from or to covered hospitals otherwise required by this part and shall promulgate rules that:

(i) Establish the methodology for determining the amounts, categories, and times of payments to hospitals, if any, instead of the payments that otherwise would have been paid under § 71-5-1705(d)(3) if approved by CMS;

(ii) Prioritize payments to hospitals as set forth in § 71-5-1705(d)(3);

(iii) Identify the benefits and services for which funds will be available in order to mitigate reductions or eliminations that otherwise would be imposed in the absence of the coverage assessment;

(iv) Determine the amount and timing of payments for

benefits and services identified under subdivisions (i)(2)(A)(ii) and (iii) as appropriate;

(v) Reinstitute payments from or to covered hospitals as appropriate; and

(vi) Otherwise achieve the goals of this subdivision (i)(2).

(B) The rules adopted under this subdivision (i)(2) shall, to the extent possible, achieve the goals of:

(i) Maximizing the amount of federal matching funds available for the TennCare program; and

(ii) Minimizing the variation between payments hospitals will receive under the rules as compared to payments hospitals would have received if CMS had approved the total payments described in § 71-5-1705(d).

(C) Notwithstanding any other law, the bureau is authorized to exercise emergency rulemaking authority to the extent necessary to meet the objectives of this subdivision (i)(2).

(3) Upon occurrence of any of the events set forth in subdivision (i)(1) or (i)(2), the bureau shall then have authority to make necessary changes to the TennCare budget to account for the loss of annual coverage assessment revenue.

(j) A covered hospital or an association representing covered hospitals, the membership of which includes thirty (30) or more covered hospitals, shall have the right to file a petition for declaratory order pursuant to § 4-5-223 to determine if there has been a failure to meet any of the requirements of this part. A covered hospital may not increase charges or add a surcharge based on, or as a result of, the annual coverage assessment.

71-5-1705.

(a) The funds generated as a result of this part shall be deposited in the maintenance of coverage trust fund created by § 71-5-160, the existence of which is continued as provided in subsection (b). The fund shall not be used to replace any monies otherwise appropriated to the TennCare program by the general assembly or to replace any monies appropriated outside of the TennCare program.

(b) The maintenance of coverage trust fund shall continue without interruption and shall be operated in accordance with § 71-5-160 and this section.

(c) The maintenance of coverage trust fund shall consist of:

(1) The balance of the trust fund remaining as of June 30, 2018;

(2) All annual coverage assessments received by the bureau;

(3) Investment earnings credited to the assets of the maintenance of coverage trust fund; and

(4) Penalties paid by covered hospitals for late payment of assessment installments as described in § 71-5-1704(d).

(d) Monies credited or deposited to the maintenance of coverage trust fund, together with all federal matching funds, shall be available to and used by the bureau only for expenditures in the TennCare program and shall include the following purposes:

(1) Expenditure for benefits and services under the TennCare program, including those that would have been subject to reduction or elimination from TennCare funding for FY 2018-2019, except for the availability of one-time funding for that year only, as follows:

(A) Replacement of across-the-board reductions in covered and excluded hospital and professional reimbursement rates described in the governor's recommended budgets since FY 2011;

(B) Maintenance of essential access hospital payments, which may be reclassified to a virtual DSH payment or unreimbursed charity

care pool payment in accordance with, and as those payments are defined in, the TennCare 1115 demonstration waiver from the centers for medicare and medicaid services, to the maximum allowed by CMS under the TennCare waiver of at least one hundred million dollars ($100,000,000);

(C) Maintenance of disproportionate share hospital payments, which may be reclassified to a virtual DSH payment or unreimbursed charity care pool payment in accordance with, and as those payments are defined in, the TennCare 1115 demonstration waiver from the centers for medicare and medicaid services, to the maximum allowed by CMS under the TennCare waiver of at least eighty-one million six hundred thousand dollars ($81,600,000);

(D) Maintenance of payments to critical access hospitals, which may be reclassified to a virtual DSH payment or unreimbursed charity care pool payment in accordance with, and as those payments are defined in, the TennCare 1115 demonstration waiver from the centers for medicare and medicaid services, to achieve reimbursement of full cost of benefits provided to TennCare enrollees up to ten million dollars ($10,000,000);

(E) Maintenance of payments for graduate medical education of at least fifty million dollars ($50,000,000);

(F) Maintenance of reimbursement for medicare part A crossover claims at the lesser of one hundred percent (100%) of medicare allowable or the billed amount;

(G) Avoidance of any coverage limitations relative to the number of hospital inpatient days per year or the annual cost of inpatient services for a TennCare enrollee;

(H) Avoidance of any coverage limitations relative to the number of nonemergency outpatient visits per year for a TennCare enrollee;

(I) Avoidance of any coverage limitations relative to the number of physician office visits per year for a TennCare enrollee;

(J) Avoidance of coverage limitations relative to the number of laboratory and diagnostic imaging encounters per year for a TennCare enrollee;

(K) Maintenance of coverage for occupational therapy, physical therapy, and speech therapy services;

(L) In the total amount of five hundred seventy-three thousand two hundred dollars ($573,200) to maintain reimbursement at the same emergency care rate as in FY 2017-2018 for nonemergent care to children twelve (12) to twenty-four (24) months of age;

(M) In the total amount of two million forty-eight thousand five hundred dollars ($2,048,500) to the bureau to offset the elimination of the provision in the TennCare managed care contractor risk agreements for hospitals as follows:

> CRA 2.12.9.60-Specify in applicable provider agreements that all providers who participate in the federal 340B program give TennCare MCOs the benefit of 340B pricing;

and

(N) In the total amount of one hundred twenty-five thousand dollars ($125,000) to offset a portion of the hospital cost of providing admissions, discharge, and transfer (ADT) messages to the TennCare bureau to support the TennCare Patient Centered Medical Home initiative;

(2) Directed payments to hospitals to offset unreimbursed costs

incurred by covered hospitals in providing services to TennCare patients, as approved by CMS. "Unreimbursed TennCare costs" means the excess of TennCare cost over TennCare net revenue. TennCare charges and net revenue are calculated using data from Schedule E, items (A)(1)(e) and (A)(1)(f) from the hospital's 2016 joint annual report (JAR) filed with the department of health. "TennCare costs" means the product of a facility's cost-to-charge ratio, calculated as B(3) divided by A(3)(e) from Schedule E of the 2016 JAR, times TennCare charges. The amount of the directed payment to covered hospitals shall be no less than forty-six and eighty-nine hundredths percent (46.89%) of unreimbursed TennCare cost for all hospitals licensed by the state that reported unreimbursed TennCare cost on the 2016 joint annual report (JAR), excluding state-owned hospitals. If directed payments to hospitals authorized by CMS do not fully cover the amount of the hospital unreimbursed TennCare costs required to be reimbursed by this subdivision (d)(2), then the remaining balance in the trust fund shall be used to offset the remaining unreimbursed TennCare costs required to be reimbursed by this section;

(3)

(A) In the event CMS does not approve directed payments to hospitals to offset unreimbursed costs incurred in serving TennCare patients, but instead approves hospital supplemental pools in the TennCare waiver for such purpose, then payments required by this subdivision (d)(3) shall be made from the allocated pools to covered hospitals to offset losses incurred in providing services to TennCare enrollees as set forth in this subdivision (d)(3) as first priority before any other supplemental payments authorized in the TennCare waiver are distributed;

(B) Each covered hospital shall be entitled to payments for FY

2018-2019 of a portion of its unreimbursed cost of providing services to TennCare enrollees. "Unreimbursed TennCare costs" means the excess of TennCare cost over TennCare net revenue. TennCare charges and net revenue are calculated using data from Schedule E, items (A)(1)(e) and (A)(1)(f) from the hospital's 2016 joint annual report (JAR) filed with the department of health. "TennCare costs" means the product of a facility's cost-to-charge ratio, calculated as B(3) divided by A(3)(e) from Schedule E of the 2016 JAR, times TennCare charges. The amount of the payment to covered hospitals shall be no less than forty-six and eighty-nine hundredths percent (46.89%) of unreimbursed TennCare costs for all hospitals licensed by the state that reported unreimbursed TennCare costs on the 2016 joint annual report (JAR), excluding state-owned hospitals;

(C) If funds are remaining for supplemental pools in the TennCare waiver authority after payments to covered hospitals for uncompensated costs of serving TennCare patients as required in this subdivision (d)(3), the bureau shall allocate the remaining supplemental payments approved by CMS across the following categories: payments to essential access hospitals, payments to hospitals based on their status as medicaid disproportionate share hospitals, and payment to the state for certified public expenditures recognized by CMS;

(D) The payments required by this subdivision (d)(3) shall be made in four (4) equal installments. Each installment payment shall be made by the third business day of four (4) successive periods within 2018-2019, with the first period to be the 15th day of the month in which the annual coverage assessment is first levied in accordance with § 71-5-1704. The bureau shall provide to the Tennessee Hospital

Association a schedule showing the payments to each hospital at least seven (7) days in advance of the payments; and

(E) The payments required by this subdivision (d)(3) may be made by the bureau directly to the hospitals, or the bureau may transfer the funds to one (1) or more managed care organizations with the direction to make payments to hospitals as required by this subsection (d). The payments to a hospital pursuant to this subdivision (d)(3) shall not be considered part of the reimbursement to which a hospital is entitled under its contract with a TennCare managed care organization;

(4) Refunds to covered hospitals based on the payment of annual coverage assessments or penalties to the bureau through error, mistake, or a determination that the annual coverage assessment was invalidly imposed; and

(5) Payments authorized under rules promulgated by the bureau pursuant to § 71-5-1704(i)(2).

(e) If a hospital closes or changes status from a covered hospital to an excluded hospital and consequently reduces the amount of the annual coverage assessment to the extent that the amount is no longer sufficient to cover the total cost of the items included in subsection (d), the payments for these items may be adjusted by an amount equal to the shortfall, including the federal financial participation. The items to be adjusted and the amounts of the adjustments shall be determined by the bureau in consultation with hospitals.

(f) The bureau shall modify the contracts with TennCare managed care organizations and otherwise take action necessary to assure the use and application of the assets of the maintenance of coverage trust fund, as described in subsection (d).

(g) The bureau shall submit requests to CMS to modify the medicaid state plan, the contractor risk agreements, or the TennCare II Section 1115 demonstration project, as necessary, to implement the requirements of this part.

(h) At quarterly intervals beginning September 1, 2018, the bureau shall submit a report to the finance, ways and means committees of the senate and the house of representatives, to the health and welfare committee of the senate, and to the health committee of the house of representatives, which report shall include:

(1) The status, if applicable, of the determination and approval by CMS set forth in § 71-5-1703(b) of the annual coverage assessment;

(2) The balance of funds in the maintenance of coverage trust fund; and

(3) The extent to which the maintenance of coverage trust fund has been used to carry out this part.

(i) No part of the maintenance of coverage trust fund shall be diverted to the general fund or used for any purpose other than as set forth in this part.

71-5-1706. This part shall expire on June 30, 2019; provided, however, that the following rights and obligations shall survive such expiration:

(1) The authority of the bureau to impose late payment penalties and to collect unpaid annual coverage assessments and required refunds;

(2) The rights of a covered hospital or an association of covered hospitals to file a petition for declaratory order to determine compliance with this part;

(3) The existence of the maintenance of coverage trust fund and the obligation of the bureau to use and apply the assets of the maintenance of coverage trust fund; and

(4) The obligation of the bureau to implement and maintain the requirements of § 71-5-161.

SECTION 2. Tennessee Code Annotated, Section 71-5-1605(d)(1), is amended by adding the following as a new subdivision:

( ) In the total amount of one hundred ninety-one thousand two hundred forty-seven dollars ($191,247) for FY 2013 through November 2017 TennCare rate variation adjustment for any hospital that was within the scope but not included in the rate

variation implementation required by § 71-5-161 to be paid upon the effective date of this act.

SECTION 3. Section 2 shall take effect on becoming a law, the public welfare requiring it, and all other provisions of this act shall take effect July 1, 2018, the public welfare requiring it.

House Health Subcommittee Am. #2

Amendment No._____

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____

_____

Signature of Sponsor

AMEND Senate Bill No. 2026 **House Bill No. 2084***

by adding the following at the end of the amendatory language of Section 1:

71-5-1707. The comptroller of the treasury is authorized to audit the expenditure of funds pursuant to this part from the maintenance of coverage trust fund. At the discretion of the comptroller of the treasury, the audit may be prepared by a certified public accountant, a public accountant, or by the department of audit. Notwithstanding § 71-5-1705, the bureau of TennCare and the maintenance of coverage trust fund must bear the full costs of the audit.

House Health Subcommittee Am. #1

Amendment No._____

_____
Signature of Sponsor

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____
_____

AMEND Senate Bill No. 2498 **House Bill No. 2321***

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Title 63, Chapter 1, Part 1, is amended by adding the following as a new section:

Any person practicing ultrasound sonography in a nonclinical 3D/4D ultrasound boutique setting, as defined by the commissioner of health by rule pursuant to § 68-1-103(a), in this state shall be at least eighteen (18) years of age and shall be in compliance with the following requirements:

(1) Earn a minimum of a technical certificate from a sonography program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or Canadian Medical Association (CMA); and

(2)

(A) Be currently certified by the American Registry for Diagnostic Medical Sonography (ARDMS) in the specialty in which they are currently practicing;

(B) Be currently certified by the American Registry of Radiologic Technologists (ARRT) in sonography;

(C) Be in the process of applying for registration with the ARDMS, provided that the applicant satisfies the requirements for registration within ninety (90) days of becoming employed as a sonographer; or

(D) Be in the process of applying for registration with the ARRT, provided that the applicant satisfies the requirements for registration within ninety (90) days of becoming employed as a sonographer.

SECTION 2. This act shall take effect January 1, 2019, the public welfare requiring it.

House Health Subcommittee Am. #1

Amendment No._____

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____

_____

Signature of Sponsor

AMEND Senate Bill No. 1977* House Bill No. 2180

by deleting SECTION 1 and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 68-1-136(g), is amended by deleting the subsection and substituting the following:

(g)

(1) Except as otherwise provided in subdivision (g)(2), a program established pursuant to this section shall not conduct an exchange within two thousand feet (2,000') of any school or public park.

(2) A program established pursuant to this section shall not conduct an exchange within one thousand feet (1,000') of any school or public park. This subdivision (g)(2) applies only to a:

(A) County having a metropolitan form of government with a population of more than five hundred thousand (500,000), according to the 2010 federal census or any subsequent federal census; and

(B) Municipality with a population in excess of one hundred sixty-five thousand (165,000), according to the 2010 federal census or any subsequent federal census.

House Health Subcommittee Am. #1

Amendment No._____

_____
Signature of Sponsor

FILED
Date _____
Time _____
Clerk _____
Comm. Amdt. _____

AMEND Senate Bill No. 2349* **House Bill No. 2540**

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Title 68, is amended by adding Sections 2 through 9 as a new chapter.

SECTION 2. This chapter shall be known and may be cited as the "Medical Cannabis Safe Access Act."

SECTION 3. As used in this chapter, unless the context requires otherwise:

(1) "Cannabis" means the dried flowers of the female cannabis plant or any mixture or preparation of the flowers, but does not include seeds, stalks, leaves, or roots of the plant;

(2) "Cardholder" means a qualifying patient who has been diagnosed with a qualifying medical condition by a practitioner and certified for participation in the Safe Access Program and who possesses a valid program identification card;

(3) "Caregiver" means a person who provides personal care, support, or assistance to a qualifying patient, including, but not limited to, a parent or legal guardian of a qualifying patient less than eighteen (18) years of age;

(4) "Licensed dispensary" means an entity that has been established to dispense medical cannabis in all its allowable forms from the Safe Access Program to eligible Tennessee patients and in accordance with rules promulgated under the authority of this chapter by the board of pharmacy;

(5) "Licensed processor" means an entity licensed and registered under Section 7 that processes, packages, and delivers medical cannabis or related supplies and educational materials to licensed dispensaries;

(6) "Licensed producer" means an entity licensed and registered under Section 7 that possesses, cultivates, processes, manufactures, packages, and delivers medical cannabis or related supplies and educational materials to licensed processors;

(7) "Medical use" means the acquisition, possession, use, or transportation of cannabis or paraphernalia relating to the consumption of cannabis to alleviate a registered patient's qualifying medical condition or its symptoms;

(8) "Practitioner" means a person who is licensed with authority to prescribe drugs pursuant to title 63, chapter 7 or 19, or a physician licensed with authority to prescribe drugs in this state under title 63, chapter 6 or 9;

(9) "Program" means the Safe Access Program as administered or regulated by the department of agriculture, department of health, and the board of pharmacy or any entity authorized to administer the Safe Access Program pursuant to a rule promulgated by the department of agriculture, department of health, or board of pharmacy in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5;

(10) "Program identification card" means a document issued by a licensed dispensary that identifies a person as a registered qualifying patient in the Safe Access Program;

(11) "Qualifying medical condition" means:

(A) Cancer;

(B) Human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS);

(C) Hepatitis C;

(D) Amyotrophic lateral sclerosis (ALS);

(E) Post-traumatic stress disorder (PTSD);

(F) Alzheimer's disease;

(G) Severe arthritis;

(H) Inflammatory bowel disease, including Crohn's disease and ulcerative colitis;

(I) Multiple sclerosis (MS);

(J) Parkinson's disease;

(K) Lyme disease;

(L) A chronic or debilitating disease or medical condition, with a confirmation of diagnosis, or the treatment of such disease or condition that produces one (1) or more of the following:

(i) Cachexia or wasting syndrome;

(ii) Peripheral neuropathy;

(iii) Severe chronic pain;

(iv) Severe nausea;

(v) Seizures, including those characteristic of epilepsy; or

(vi) Severe or persistent muscle spasms;

(M) Any medical condition for which a patient receives hospice services, as defined in § 68-11-201;

(N) Any patient prescribed or otherwise receiving opioid treatment from a practitioner for any condition; and

(O) Any other medical condition approved by the medical cannabis advisory committee in response to a request from a practitioner or potentially qualifying patient or a proposal initiated by a member of the commission;

(12) "Qualifying patient" means a person who has been diagnosed with a qualifying medical condition by a practitioner and is a resident of Tennessee, except as provided in Section 4(i), or the person's designated and registered caregiver;

(13) "Registry identification card" means a program identification document issued to a principal officer, board member, agent, volunteer, or employee of a licensed producer, licensed processor, or licensed dispensary;

(14) "Resident of Tennessee" means a person who is a resident for purposes of eligibility for medical assistance under title 71, chapter 5, part 1; and

(16) "Safe Access Program enrollment" means that a qualifying patient has received a certification for medical cannabis from a practitioner and complied with Section 5(a) of this act.

SECTION 4.

(a) A qualifying patient who possesses a program identification card shall not be subject to arrest, prosecution, or penalty in any manner or denied any right or privilege, including, but not limited to, a civil penalty or disciplinary action by a business or an occupational or professional licensing board or commission for the medical use of cannabis; provided, that the qualifying patient is enrolled in the Safe Access Program.

(b) No school, employer, or landlord may refuse to enroll, employ, or lease to or otherwise penalize a person solely for the person's status as a cardholder.

(c) A registered cardholder who is a qualifying patient may possess a reasonable amount of cannabis, not to exceed one (1) month's supply, as determined by the patient's practitioner.

(d)

(1) There exists a rebuttable presumption that a qualifying patient is engaged in the medical use of cannabis if the qualifying patient:

(A) Is in possession of a program identification card; and

(B) Is in possession of an amount of cannabis that does not exceed the amount permitted under this chapter.

(2) The presumption may be rebutted by evidence that conduct related to cannabis was not for the purpose of alleviating the qualifying patient's debilitating medical condition or symptoms associated with the medical condition.

(e) A practitioner shall not be subject to arrest, prosecution, or penalty in any manner or denied any right or privilege, including, but not limited to, civil penalty or disciplinary action by the board of medical examiners or by a business or an occupational or professional licensing board or commission of this state solely for providing written certifications or for otherwise stating that, in the practitioner's professional opinion, the potential benefits of medical cannabis would likely outweigh the health risks for a qualifying patient.

(f) Any interest in or right to property that is possessed, owned, or used in connection with the medical use of cannabis, or acts incidental to such use, shall not be forfeited.

(g) No person shall be subject to arrest or prosecution for constructive possession, conspiracy, aiding and abetting, being an accessory, or any other offense for simply being in the presence or vicinity of the medical use of cannabis as permitted under this chapter or for assisting a registered Safe Access Program patient with using or administering medical cannabis.

(h) A practitioner or nurse shall not be subject to arrest, prosecution, or penalty in any manner or denied any right or privilege, including, but not limited to, civil penalty or disciplinary action by a business or an occupational or professional licensing board or commission solely for discussing the benefits or health risks of medical cannabis or its interaction with other substances with a patient or for providing certification of a patient's eligibility for the Safe Access Program to licensed dispensaries.

(i) A program identification card or its equivalent issued under the laws of another state, United States territory, or the District of Columbia to permit the medical use of cannabis by a patient with a debilitating medical condition, or to permit a person

to assist with the medical use of cannabis by a patient with a debilitating medical condition, shall not have the same force and effect as a program identification card. An out-of-state patient must be evaluated and certified for Safe Access Program participation by a practitioner licensed and qualified to do so in this state in order to obtain medical cannabis from the Safe Access Program.

(j) For purposes of medical care, including organ transplants, a registered qualifying patient's authorized use of cannabis is considered the equivalent of the authorized use of any other medication used at the direction of a physician and does not constitute the use of an illicit substance.

SECTION 5.

(a) Enrollment in the Safe Access Program shall be conducted at licensed dispensaries. For a qualifying patient to be enrolled in the program:

(1) The qualifying patient's practitioner, with whom the patient has a bona fide patient-practitioner relationship, shall complete a full assessment of the qualifying patient's medical history;

(2) The qualifying patient's practitioner shall specify the qualifying patient's qualifying medical condition or conditions and state that in the practitioner's professional opinion the potential benefits of the medical use of cannabis would likely outweigh the health risks for the qualifying patient; and

(3) The certification and Safe Access Program enrollment completed at the licensed dispensary shall certify the qualifying patient's qualifying medical condition or conditions.

(b) The program shall issue program identification cards to qualifying patients who receive a certification for medical cannabis and complete the Safe Access Program enrollment process at a licensed dispensary. Patients shall provide the following information to the Safe Access Program:

(1) Name, address, and date of birth of the qualifying patient; provided, however, that if the patient is homeless, no address is required; and

(2) Name, address, and telephone number of the qualifying patient's practitioner.

(c) The program shall not issue a program identification card to a qualifying patient under eighteen (18) years of age unless:

(1) The qualifying patient's practitioner has explained the potential risks and benefits of the medical use of cannabis to the qualifying patient and to a parent, guardian, or person having legal custody of the qualifying patient; and

(2) The parent, guardian, or person having legal custody consents in writing to:

(A) Allow the qualifying patient's medical use of cannabis; and

(B) Control the acquisition of the cannabis, the dosage, and the frequency of the medical use of cannabis by the qualifying patient.

(d)

(1) The Safe Access Program shall verify the information contained in a Safe Access Program application or renewal submitted pursuant to this section and shall approve or deny an application or renewal within thirty (30) days of receiving it.

(2) The Safe Access Program shall deny a Safe Access Program application or renewal only if the applicant did not provide the information required pursuant to this section or if the program determines that the information provided was falsified.

(3) Rejection of a Safe Access Program application or renewal is considered a final program action, subject to judicial review.

(4) Jurisdiction and venue for judicial review are vested in the chancery court of Davidson County.

(e) A licensed dispensary shall complete the patient application and submit it to the Safe Access Program. Once a qualifying patient is approved, the dispensary shall issue the Safe Access Program identification card to the qualifying patient. The program shall issue a program identification card at the time of enrollment into the program, which shall expire no later than one (1) year after the date of issuance.

(f) Program identification cards shall contain:

(1) The date of issuance and expiration date of the identification card;

(2) A random program identification number; and

(3) Any additional information as required by rule or the program.

(g) A person who is issued a program identification card is subject to the following:

(1) A qualifying patient who has been issued a program identification card shall notify the patient's practitioner or dispensary of any change in the patient's name or address or if the patient ceases to have the patient's qualifying medical condition within thirty (30) days of such change;

(2) A registered qualifying patient who fails to notify the patient's practitioner or dispensary of any changes requiring notification is subject to a civil penalty of twenty-five dollars ($25.00). If the patient ceases to suffer from a qualifying medical condition, the card shall be deemed void, and the patient shall be liable for any other penalties that may apply to the patient's nonmedical use of cannabis;

(3) When a qualifying patient notifies the patient's practitioner of any changes listed in this subsection (g), the practitioner shall issue the patient a certification to be used to update Safe Access Program information with the licensed dispensary;

(4) When a qualifying patient who possesses a program identification card changes practitioners, the new practitioner shall assume responsibility for

the patient's Safe Access Program participation and shall issue a new certification to update the patient's Safe Access Program information to reflect the change. No more than one (1) certification from one (1) practitioner is allowed for safe access participants;

(5) If a cardholder's program identification card is lost, the cardholder shall notify the licensed dispensary and submit a fee of ten dollars ($10.00) to receive a replacement card; and

(6) If a cardholder knowingly violates any provision of this chapter as determined by the program, the program identification card may be revoked.

(h) Possession of a program identification card shall not constitute probable cause or reasonable suspicion nor shall it be used to support the search of the person or property of the person possessing or applying for the program identification card nor otherwise subject the person or property of the person to inspection by any governmental agency.

(i)

(1) A program identification card and the supporting information submitted by a qualifying patient, including information regarding the patient's practitioner, is confidential and protected under the federal Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191), as amended.

(2) The program shall maintain a confidential list of Safe Access Program participants whose practitioners have certified them in the program and to whom the program has issued program identification cards. Individual names and other identifying information on the list are considered confidential and exempt from the public record provisions of title 10, chapter 7, part 5, and are not subject to disclosure, except to authorized employees of the program as necessary to perform official duties of the program.

(j) The program shall verify to law enforcement personnel whether a program identification card is valid solely by confirming the program identification number.

(k)

(1) Any person, including an employee or official of the program or its licensees or another state agency or local government, who knowingly breaches the confidentiality of information obtained pursuant to this chapter commits a Class B misdemeanor, punishable only by a fine of one thousand dollars ($1,000).

(2) Notwithstanding subdivision (k)(1), a Safe Access Program employee shall notify law enforcement about falsified or fraudulent information submitted to the program.

(l) On or before January 31 of each even-numbered year, beginning in 2020, the department of agriculture, board of pharmacy, and department of health shall report to the general assembly on the performance of the Safe Access Program. The report shall provide:

(1) The number of patients enrolled in the Safe Access Program;

(2) The nature of the debilitating medical conditions of the patients;

(3) The number of practitioners providing Safe Access Program certification for qualifying patients;

(4) The number of licensed producers, processors, and dispensaries;

(5) An evaluation of the costs and benefits of the Safe Access Program for patients, practitioners, and the general public, including any costs and benefits to law enforcement agencies, producers, small businesses, the courts, and hospitals;

(6) Statistics regarding the number of cannabis-related prosecutions against registered patients and caregivers and licensed producers, processors, and dispensaries and an analysis of the facts underlying those prosecutions;

(7) Statistics regarding the number of prosecutions against practitioners for violations of this chapter; and

(8) Updates on national policy and practice associated with influencing the access of qualified patients to medical cannabis.

(m) The application for a qualifying patient's program identification card shall include a statement indicating that the program may contact the patient to obtain information about Safe Access Program participation, including experiences with using medical cannabis, in a systematic effort to inform future Safe Access Program policies and practices.

SECTION 6.

(a) A person shall not:

(1) Undertake any task under the influence of cannabis when doing so would constitute negligence or professional malpractice;

(2) Use cannabis:

(A) In a school bus or other form of public transportation;

(B) On school grounds;

(C) In any correctional facility;

(D) In any public place; or

(E) Where exposure to cannabis significantly and adversely affects the health, safety, or welfare of children; or

(3) Operate, navigate, or be in actual physical control of any motor vehicle, aircraft, or motorboat while under the influence of cannabis. However, a registered qualifying patient shall not be considered to be under the influence solely for having cannabis metabolites in the patient's system.

(b) Nothing in this chapter requires:

(1) A government medical assistance program or private health insurer to reimburse a person for costs associated with the medical use of cannabis; or

(2) An employer to accommodate medical cannabis in any workplace.

(c) A person who makes a fraudulent representation of any fact or circumstance relating to the medical use of cannabis to a law enforcement official to avoid arrest or prosecution commits a Class C misdemeanor.

SECTION 7.

(a) A licensed producer registered under this section may possess, cultivate, harvest, package, and deliver cannabis or related products to a licensed processor. The department of agriculture shall regulate licensed producers.

(b) A licensed processor registered under this section may possess, process, package, and deliver cannabis or related products to licensed dispensaries. The department of agriculture shall regulate licensed processors.

(c)

(1) A licensed dispensary is the point of distribution of medical cannabis to Safe Access Program participants.

(2) The board of pharmacy shall regulate licensed dispensaries.

(3) Except as specifically provided to the contrary, all provisions of this chapter apply to a licensed producer, licensed processor, or licensed dispensary.

(d)

(1) No later than one hundred twenty (120) days after the effective date of this act, the commissioner of agriculture, the board of pharmacy, and the commissioner of health shall promulgate rules governing the consideration of applications and qualifications of applicants for registration certificates for licensed producers, licensed processors, and licensed dispensaries, including:

(A) The form and content of registration and renewal applications;

(B) Minimum oversight requirements for these entities;

(C) Minimum record-keeping requirements for these entities;

(D) Minimum security requirements for these entities; and

(E) Procedures for suspending or revoking the registration of these entities that violate this section or the regulations promulgated pursuant to this subsection (d), including procedures for providing notice and hearing regarding the suspension or revocation of a registration certificate.

(2) No later than one hundred twenty (120) days after the effective date of this act, the program shall begin accepting applications for the operation of licensed producers, licensed processors, and licensed dispensaries.

(3) No later than one hundred eighty (180) days after the effective date of this act, the program shall provide for at least one (1) public hearing on the granting of applications for licensed producers, licensed processors, and licensed dispensaries.

(4) No later than two hundred ten (210) days after the effective date of this act, the program shall grant registration certificates to licensed producers, licensed processors, and licensed dispensaries; provided, that each applicant meets the requirements of this chapter.

(5) After completion of subdivisions (d)(2)-(4), the program shall accept new applications during the following periods each year:

(A) January 15 through January 31; and

(B) July 15 through July 31.

(6) No later than April 15 and October 15 of each year, the program shall:

(A) Review applications received during the most recent period identified in subdivision (d)(5);

(B) Solicit public comments regarding the issuance of registration certificates to additional licensed producers, licensed processors, and licensed dispensaries; and

(C) Issue registration certificates to qualified applicants after consideration of public comments and identified and anticipated needs of the Safe Access Program and its participants.

(e)

(1) Each application for a licensed producer, processor, or dispensary shall include:

(A) A nonrefundable application fee paid to the Safe Access Program in the amount of two hundred fifty dollars ($250);

(B) The proposed legal name and proposed articles of incorporation or charter and bylaws of the licensed producer, processor, or dispensary;

(C) The proposed physical address of the licensed producer, processor, or dispensary if a precise address has been determined, or, if no precise address yet exists, the general location where it would be located. This also includes any other locations used for the Safe Access Program;

(D) A description of the enclosed, locked facilities to be used in the cultivation of cannabis;

(E) The name, address, and date of birth of each principal officer and board member of the licensed producer, processor, or dispensary;

(F) Proposed security and safety measures, which shall include at least one (1) security alarm system for each location, a plan for deterring and preventing any unauthorized entrance into areas containing cannabis and the theft of cannabis, as well as an employee instruction manual that includes security policies, safety and security procedures, and personal safety and crime prevention techniques; and

(G) Proposed procedures to ensure accurate record keeping.

(2) Each time one (1) or more licensed producer, processor, or dispensary registration applications are being considered, the program shall provide an opportunity for public comment and shall solicit input from registered qualifying patients, potential patients, practitioners, and local governmental officials where the applicants would be located.

(3) Each time a licensed producer, processor, or dispensary certificate is granted, the decision shall be based upon an assessment of the licensed producer's or licensed processor's ability to serve the overall health needs of Safe Access Program patients and the safety of the public, including, but not limited to, the following factors:

(A) Convenience to patients throughout the state if the applicant were approved;

(B) The applicant's ability to provide a significant supply to the registered qualifying patients through the Safe Access Program;

(C) The applicant's experience running a business or nonprofit organization;

(D) The input from local governmental officials, including law enforcement officials, where the producer, processor, or dispensary is or will be located;

(E) The sufficiency of the applicant's plans for record keeping and security. The records shall be considered confidential information under state law and deemed protected healthcare information for purposes of the federal Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191), as amended; and

(F) The sufficiency of the applicant's plans for safety and security, including proposed location, security devices employed, and staffing.

(4) After a licensed producer, processor, or dispensary is approved, but before it begins operations, it shall submit the following to the program:

(A) A fee paid to the Safe Access Program in the amount of one thousand dollars ($1,000);

(B) The legal name and articles of incorporation or charter and bylaws of the licensed producer, processor, or dispensary;

(C) The physical address of the licensed producer, processor, or dispensary, including any other address for Safe Access Program-related facilities;

(D) The name, address, and date of birth of each principal officer and board member of the licensed producer, processor, or dispensary;

(E) The name, address, and date of birth of any person who will be an agent of or employed by the licensed producer, processor, or dispensary at its inception; and

(F) A signed and notarized agreement for appropriate persons to be trained, supervised, and monitored by Safe Access Program staff or contractors or both.

(5) The program shall track the performance of each licensed producer, processor, or dispensary and issue a written statement of performance to each licensed producer, processor, or dispensary semi-annually, as determined by the program. Licensed producers, processors, and dispensaries shall maintain compliance with all Safe Access Program rules and requirements at all times.

(6) Except as provided in subdivision (e)(7), the program shall issue each principal officer, board member, agent, volunteer, and employee of a licensed producer, processor, or dispensary a registry identification card or renewal card within thirty (30) days of receipt of the person's name, address, date of birth, and a fee in an amount established by the program. Each card shall specify that the

cardholder is a principal officer, board member, agent, volunteer, or employee of a program entity and shall contain the following information:

(A) The name, address, and date of birth of the principal officer, board member, agent, volunteer, or employee;

(B) The legal name of the licensed producer, processor, or dispensary with which the principal officer, board member, agent, volunteer, or employee is affiliated;

(C) A random identification number unique to the cardholder;

(D) The date of issuance and expiration date of the registry identification card;

(E) A photograph, if the program requires one; and

(F) Verification that the principal officer, board member, agent, volunteer, or employee has completed a criminal history records check by the Tennessee bureau of investigation.

(7)

(A) Except as otherwise provided in subdivision (e)(7)(D), the program shall not issue a registry identification card to any principal officer, board member, agent, volunteer, or employee of a licensed producer, processor, or dispensary who has been convicted of a felony offense under title 39, chapter 17, part 4.

(B) The program shall conduct a criminal history records check of each principal officer, board member, agent, volunteer, or employee in order to carry out this subdivision (e)(7).

(C) The program shall notify the licensed producer, processor, or dispensary in writing of the purpose for denying the registry identification card.

(D) The program may grant the person a registry identification card if the program determines that the offense was for conduct that occurred prior to the enactment of this chapter or that was prosecuted by an authority other than the state of Tennessee and for which this chapter would otherwise have prevented a conviction, including the cultivation of cannabis.

(8) A registry identification card of a principal officer, board member, agent, volunteer, or employee shall expire one (1) year after its issuance, or upon the expiration of the registered organization's registration certificate, whichever occurs first.

(f)

(1) A licensed producer's, processor's, or dispensary's registration certificate shall expire two (2) years after the certificate is issued. The licensed producer, processor, or dispensary may submit a renewal application no earlier than sixty (60) days before the expiration of its registration certificate.

(2) The program shall renew a licensed producer's, processor's, or dispensary's registration certificate no later than thirty (30) days after the receipt of the renewal application if the following conditions are satisfied:

(A) The licensed producer, processor, or dispensary submits the materials required under subdivision (e)(4), including the one-thousand-dollar fee;

(B) The licensed producer's, processor's, or dispensary's registration certificate has not been suspended or revoked at any time for violations of this chapter or rules promulgated pursuant to this chapter;

(C) The medical cannabis advisory committee's report, issued pursuant to Section 8, indicates that the licensed producer, processor, or

dispensary adequately provides Tennessee patients with access to medical cannabis; and

(D) The advisory committee's report, issued pursuant to Section 8, does not raise serious concerns about the continued operation of the licensed producer, processor, or dispensary applying for renewal.

(3) If the program determines that any of the conditions listed in subdivision (f)(2) require the program to suspend or revoke a registration certificate, the program shall:

(A) Provide notice and hearing to a licensed producer, processor, or dispensary prior to revoking a registration certificate; and

(B) Initiate an open application process to replace the operation of the producer, processor, or dispensary that has had a registration certificate suspended or revoked. In granting a new registration certificate, the program shall consider factors listed in subdivision (e)(3).

(4) The program shall issue a licensed producer, processor, or dispensary one (1) or more thirty-day temporary registration certificates to replace the licensed producer's, processor's, or dispensary's registration certificate scheduled to expire if the following conditions are satisfied:

(A) The licensed producer, processor, or dispensary previously applied for a renewal, but the program did not reach a decision;

(B) The licensed producer, processor, or dispensary requested a temporary registration certificate; and

(C) The licensed producer's, processor's, or dispensary's registration certificate has not been suspended or revoked at any time for violations of this chapter or rules promulgated pursuant to this chapter.

(g) Licensed producers and processors are subject to reasonable inspection by the department of agriculture. Licensed dispensaries are subject to reasonable

inspection by the board of pharmacy. A department or board shall give reasonable notice of an inspection under this subsection (g). During an inspection, the department or board may review the licensed producer's, processor's, or dispensary's confidential records, including its dispensing records, which may track transactions according to registry identification numbers to protect patient confidentiality.

(h)

(1) A licensed producer, processor, or dispensary shall operate for the mutual benefit of Tennessee patients. A licensed producer, processor, or dispensary need not be recognized as a tax-exempt organization by the internal revenue service.

(2) A licensed producer, processor, or dispensary shall not be located within five hundred feet (500') of the property line of a preexisting school.

(3) A licensed producer, processor, or dispensary shall notify the program no later than thirty (30) days after a principal officer, board member, agent, volunteer, or employee ceases to work at the licensed producer, processor, or dispensary, and the person's card shall be deemed void.

(4) A licensed producer, processor, or dispensary shall notify the program in writing of the name, address, and date of birth of any new principal officer, board member, agent, volunteer, or employee and shall remit a fee in an amount established by the program for a new registry identification card before the new agent or employee begins working at the licensed producer, processor, or dispensary.

(5) A licensed producer, processor, or dispensary shall implement appropriate security measures to deter and prevent the unauthorized entrance into areas containing cannabis and the theft of cannabis and shall insure that each location has an operational security alarm system.

(6) The operating documents of a licensed producer, processor, or dispensary shall include procedures for the oversight of the licensed producer, processor, or dispensary and procedures to ensure accurate recordkeeping.

(7) A licensed producer, processor, or dispensary is prohibited from acquiring, possessing, cultivating, manufacturing, delivering, transferring, transporting, supplying, or dispensing cannabis for any purpose except to assist registered Safe Access Program cardholders.

(8) Each time a new, registered cardholder visits a licensed dispensary, the licensed dispensary shall provide the cardholder with instructional materials designed by the Safe Access Program to answer frequently asked questions and explain the limitations on the right to use medical cannabis under this chapter.

(9) Each licensed producer, processor, or dispensary shall develop, implement, and maintain on the premises employee and agent policies and procedures to address the following requirements:

(A) A job description or employment contract developed for all employees and a volunteer agreement for all volunteers that includes duties, authority, responsibilities, qualification, and supervision; and

(B) Training in and adherence to state confidentiality laws.

(10) Each licensed producer, processor, or dispensary shall maintain a personnel record for each employee and each volunteer that includes an application for employment or to volunteer and a record of any disciplinary action taken.

(11) Each licensed producer, processor, or dispensary shall develop, implement, and maintain on the premises an on-site training curriculum or contract with a person or entity capable of meeting employee training needs, including, but not limited to, the following topics:

(A) Professional conduct, ethics, and patient confidentiality; and

(B) Informational developments in the field of medical cannabis.

(12) Each licensed producer, processor, or dispensary entity shall provide each employee and each volunteer, at the time of the initial appointment, training in the following:

(A) The proper use of security measures and related procedures; and

(B) Specific instructions on how to respond to emergencies.

(13) A licensed producer, processor, or dispensary shall prepare training documentation on the Safe Access Program for each employee and have the employee sign a statement indicating the date, time, and place the employee received the training, the topics discussed, and the name and title of presenters. The licensed producer, processor, or dispensary shall maintain the training documentation for a period of at least six (6) months after the termination of employment or volunteer status.

(i)

(1) No registered licensed producer, processor, or dispensary shall be subject to prosecution, a search, notwithstanding an inspection pursuant to subsection (g), a seizure, or a penalty in any manner or denied any right or privilege, including a civil penalty imposed or disciplinary action taken by a business or an occupational or professional licensing board or entity, solely for acting in accordance with this section to produce, process, or distribute medical cannabis through the Safe Access Program.

(2) No principal officer, board member, agent, volunteer, or employee of a registered licensed producer, processor, or dispensary shall be subject to an arrest, prosecution, a search, a seizure, or a penalty in any manner or denied any right or privilege, including a civil penalty imposed or a disciplinary action taken by a business or an occupational or professional licensing board or entity,

solely for working for or with a licensed producer, processor, or dispensary to engage in acts permitted by this section.

(j)

(1) A licensed producer shall not dispense, deliver, or otherwise transfer cannabis to any person or entity other than a licensed processor.

(2) A licensed processor shall not dispense, deliver, or otherwise transfer medical cannabis to any person or entity other than a licensed dispensary.

(3) A licensed dispensary shall not dispense, deliver, or otherwise transfer medical cannabis other than to a Safe Access Program cardholder.

(4) A person found to have violated subdivision (j)(1), (j)(2), or (j)(3) is not permitted to be an employee, agent, principal officer, or board member of any licensed producer, processor, or dispensary, and the person's registry identification card shall be revoked.

(5) No person who has been convicted of a felony offense under title 39, chapter 17, part 4, is permitted to be a principal officer, board member, agent, volunteer, or employee of a licensed producer, processor, or dispensary unless the program determines that the person's conviction was for the medical use of cannabis or assisting with the medical use of cannabis and issues the person a registry identification card as provided under subdivision (e)(7)(D).

(6) A person who knowingly violates this subsection (j) commits a Class C misdemeanor, punishable only by a fine of one thousand dollars ($1,000). A subsequent offense in violation of this subsection (j) is a Class B misdemeanor.

SECTION 8.

(a)

(1) Effective May 1, 2018, there is created the medical cannabis advisory committee. The committee shall consist of thirteen (13) members, including the commissioner of agriculture, commissioner of health, and executive director of

the board of pharmacy, or their designees, who shall serve as ex officio members. The remaining members shall be appointed prior to May 1, 2018, as follows:

(A) The governor shall appoint four (4) members as follows:

(i) Two (2) members who are physicians licensed under title 63, chapter 6 or 9, who may be appointed from lists of qualified persons submitted by interested medical groups and who shall serve an initial term of two (2) years; and

(ii) Two (2) members who may be appointed from lists of persons submitted by interested patient advocacy groups and who shall serve an initial term of three (3) years;

(B) The speaker of the senate shall appoint three (3) members as follows:

(i) One (1) member who is a qualifying patient;

(ii) One (1) member who is a nurse, licensed in accordance with § 63-7-105, who may be appointed from lists of qualified persons submitted by interested medical groups and who shall serve an initial term of three (3) years; and

(iii) One (1) member representing a state or local law enforcement agency, who shall serve an initial term of two (2) years; and

(C) The speaker of the house of representatives shall appoint three (3) members as follows:

(i) One (1) member who is a qualifying patient;

(ii) One (1) member who is a nurse, licensed in accordance with § 63-7-105, who may be appointed from lists of

qualified persons submitted by interested medical groups and who shall serve an initial term of two (2) years; and

(iii) One (1) member representing a state or local law enforcement agency, who shall serve an initial term of three (3) years.

(2) In making the appointments as provided in subdivision (a)(1) the appointing authorities shall:

(A) Consult with the interested groups represented on the committee to determine qualified persons to fill the positions; and

(B) Appoint members with due regard to the geographical areas where qualifying patients, licensed producers, processors, and dispensaries are located.

(b)

(1) Each appointed member shall serve a four-year term to begin May 1 and expire on April 30 of the appropriate year, unless otherwise provided in this section, and may be reappointed for successive terms.

(2) Members shall serve until a successor is appointed.

(3) Any vacancy shall be filled for the unexpired term with the appointment of a replacement member by the appropriate appointing authority.

(4) The pattern established for initial appointments shall be followed for appointments by the appropriate appointing authorities when appointments are to fill expired terms.

(c)

(1) The first meeting shall be jointly called by the commissioner of agriculture, commissioner of health, and executive director of the board of pharmacy and held no later than sixty (60) days after May 1, 2018.

(2) At the first meeting, the committee shall elect members to serve as president, vice president, and secretary. The committee may also elect any other officers it deems necessary to perform the business of the committee. An officer will serve in that position for a term of one (1) year.

(3) A quorum of seven (7) members, including at least two (2) officers, is required for the committee to conduct business.

(d) The committee shall meet at least three (3) times per year for the purpose of providing findings and making recommendations to the general assembly regarding:

(1) Tennessee patients' access to medical cannabis;

(2) Performance of licensed producers, processors, and dispensaries;

(3) Practitioner participation in the Safe Access Program;

(4) Additions to the list of qualifying medical conditions; and

(5) Research studies relevant to medical cannabis.

(e) On or before January 31 of every even-numbered year, beginning in 2020, the committee shall report to the general assembly on its findings and recommendations.

(f) The members of the committee shall receive no compensation for their services; provided, that each member of the committee shall be eligible for reimbursement of expenses and mileage in accordance with rules promulgated by the commissioner of finance and administration and approved by the attorney general and reporter.

SECTION 9. In accordance with this chapter, a person authorized by and in compliance with the Safe Access Program regarding the manufacture, delivery, sale, or possession of medical cannabis shall not be subject to arrest or prosecution under § 39-17-417(a), § 39-17-418, or § 39-17-425, if the person's activities are in accordance with this chapter.

SECTION 10. Tennessee Code Annotated, Section 4-29-241(a), is amended by adding the following as a new, appropriately designated subdivision:

Medical cannabis advisory committee, created by Section 8 of this act;

SECTION 11. Tennessee Code Annotated, Section 39-17-417, is amended by adding the following language as a new, appropriately designated subsection:

This section does not apply to persons authorized by and in compliance with the Medical Cannabis Safe Access Act, compiled in title 68, regarding the manufacture, delivery, sale, or possession of cannabis for medical use.

SECTION 12. Tennessee Code Annotated, Section 39-17-418, is amended by adding the following language as a new, appropriately designated subsection:

This section does not apply to persons authorized by and in compliance with the Medical Cannabis Safe Access Act, compiled in title 68, regarding the possession of cannabis for medical use.

SECTION 13. Tennessee Code Annotated, Section 39-17-425, is amended by deleting the language "authorized by this part and title 53, chapter 11, parts 3 and 4" wherever it appears and by substituting instead the language "authorized by this part, the Medical Cannabis Safe Access Act, compiled in title 68, and title 53, chapter 11, parts 3 and 4".

SECTION 14. If any provision of this act or the application of any provision of this act to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of the act that can be given effect without the invalid provision or application, and to that end, the provisions of this act are declared to be severable.

SECTION 15. The commissioner of agriculture, board of pharmacy, and commissioner of health are authorized to promulgate rules, as appropriate, to effectuate the purposes of this act; provided, that the commissioner of health shall promulgate any rules necessary to effectuate the purposes of Section 8. All rules shall be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in Tennessee Code Annotated, Title 4, Chapter 5.

SECTION 16. For the purposes of establishing the medical cannabis advisory committee and promulgating rules, this act shall take effect upon becoming a law, the public

welfare requiring it. For all other purposes, this act shall take effect January 1, 2019, the public welfare requiring it.